

MEDICAID / BADGERCARE MANUAL NEGATIVE NOTICE

INSTRUCTIONS: To be completed by economic support worker. Original to applicant/recipient and copy is to be put in case file.

Applicant / Recipient Name (Last, First, MI)	Case Number	Date
Address (Street, City, State, Zip Code)		

- ☐ Your application for Medicaid / BadgerCare has been denied.
- ☐ Your application for Medicaid / BadgerCare has been denied because your income exceeds the legal maximum by \$_____ per month. If you incur six times this amount \$_____, in medical bills, you may be eligible. Contact your economic support worker for details.
- ☐ Your Medicaid / BadgerCare benefits will be terminated effective _____(mm/dd/yy).
- ☐ Your Medicaid / BadgerCare application has been cancelled because you have withdrawn the application.
- ☐ _____(recipient's name) will no longer receive Medicaid / BadgerCare benefits effective _____(mm/dd/yy).
- ☐ Your Medicaid / BadgerCare premium has been increased from \$_____ to \$_____.
- ☐ Your Medicaid / BadgerCare patient liability/cost share has increased from \$_____ to \$_____.
- ☐ A decision has not yet been made on your Medicaid / BadgerCare application. See explanation below.

Explanation of Action:

Legal References:

If you have any questions, please contact (ES worker name, address and telephone number):

If you do not agree with a Medicaid decision you may appeal the decision by requesting a Fair Hearing. Fair hearing information is attached.

MEDICAID/BADGERCARE FAIR HEARING INFORMATION

If you are not satisfied with a Medicaid/BadgerCare decision you may appeal the decision by requesting a Fair Hearing in writing or in person at your local county/tribal social or human services department. You may also write to:

The Department of Administration
Division of Hearings and Appeals
PO Box 7875
Madison, WI 53707-7875
(608) 266-3096 (voice)
(608) 264-9853 (TTY)

If you need an accommodation for a disability or a language translation, please call (608) 266-3096 (voice) or (608) 264-9853 (TTY). These telephone numbers are only for the administrative hearing process.

You, your chosen representative (if any), and the local county/tribal social or human services department will receive written notice at least 10 days before the fair hearing explaining the schedule time, date and place of the hearing. The hearing will be held in the county where you live.

If you file an appeal of a discontinuation, termination, or reduction of benefits before the date the change was to take effect, your coverage can continue pending the hearing decision. The appeal should include important facts of the matter and your Medicaid ID number.

Your request must be received within 45 days of the action you are appealing.

PREPARING FOR A FAIR HEARING

You have the right to bring witnesses, your own lawyer, or some other advisor to the fair hearing. The agency cannot pay for a lawyer to represent your side of the story, but they may be able to help you find free legal assistance for questions or fair hearing representation.

You have the right, both before the hearing and during the hearing, to see the agency's written materials about the case, including your case record, upon which the agency based its decision.

You or your representative has the right to question anyone who testifies against you at the fair hearing. You also have the right to your own arguments and bring written materials showing why you think you are right.

If the fair hearing is about whether you are or are not incapacitated or disabled, you have the right to present medical evidence for proof, paid for by the agency.

If you cannot speak English or require sign language, you have the right to have an interpreter present at the hearing. The Division of Hearings and Appeals may authorize payment for necessary translation or interpreters if you ask.

CONTINUATION OF BENEFITS

If you ask for a fair hearing before the effective date of the agency's action your Medicaid benefits will not be reduced or terminated until after the results of the fair hearing are known. You are still required to report any changes in your circumstances while your hearing is pending which may affect the level of your benefits. Asking for a fair hearing does not cancel out normally scheduled interview periods.

EFFECTS OF THE FAIR HEARING

If the fair hearing decision is in your favor:

- ☐ No action will be taken against you by the agency.
- ☐ If benefits have been terminated, they will be reinstated.
- ☐ The date of reinstatement will be listed in the copy of the decision you receive, ordering the agency to reinstate your benefits.

If the fair hearing goes against you:

- ☐ The agency's action will stand and you may have to pay back the cost of any benefits you received that you should not have received.

REHEARINGS

After you have received the fair hearing decision, you have the right to ask for a rehearing if:

- ☐ You have important new evidence that you could not have made available even if you tried, before the hearing that could change the decision.
- ☐ You feel that there was a mistake in the facts of the decision.
- ☐ You feel that there was a mistake in the legal basis of the decision.

If you would like a rehearing, a written request must be received within 20 days from the date of the written decision the Division of Hearings and Appeals. The state hearing's office will decide within 30 days if a rehearing is justified.

APPEALING A FAIR HEARING OR REHEARING DECISION

If you do not agree with the fair hearing or rehearing decision, it is still possible for you to appeal to the Circuit Court in your county. This must be done within 30 days after you have received the written decision about the fair hearing or within 30 days of the denial of the rehearing request. An appeal to the Circuit Court must be completed by filing a petition with the Clerk of Courts in your county. It is best to have legal assistance, if you decide to appeal a fair hearing decision in Circuit Court.